

Cochrane Corner

Warts: what is effective and what is not

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Cutaneous viral warts, caused by the human papilloma virus (HPV), are an extremely common problem with most people experiencing them in one form or another at some time in their lives. Viral replication only takes place in fully differentiated epithelium and the subsequent proliferation results in a clinically evident warty papule or plaque. The clinical appearance of warts is variable and depends to some extent on the type of HPV involved and the anatomical site. HPV can also remain dormant within epithelial cells

without visible disease. Any epithelial surface can be affected and different types of HPV tend to favour particular anatomical sites but the commonest infections are with HPV type 2 on the hands and feet. Plane or flat warts which are clinically distinct from common warts and usually occur on the distal limbs and face are caused by HPV types 3 or 10. Genital warts do not fall within the remit of this review.

There are very few precise epidemiological data on viral warts. Most prevalence surveys have tended to use selected subsets of the population such as dermatology outpatients or school children. Two large studies of populations with a complete age range in the USA and Russia produced widely different prevalence figures for viral warts of 0.84% (Johnson 1978)

and 12.9% (Beliaeva 1990) respectively. This wide variation in prevalence figures is probably due to a combination of true variation between samples and populations, variations of study design and age-related effects.

Despite the paucity of robust data it is generally agreed that in the general population viral warts are uncommon in infancy, increasingly common in childhood reaching a peak in the teenage years with a sharply declining prevalence thereafter. Young people in institutions are at greater risk, particularly for plantar warts in communal 'bare foot' areas such as changing rooms and swimming pools. Fishmongers, butchers and other meat handlers are also known to be at greater risk of acquiring large and numerous hand warts (Melchers 1993).

Table 1. Interventions for clearing warts

Lesion	Treatment	Effectiveness	Evidence	Disadvantages
Wart	Salicylic acid	This is effective NNT = 4 over 6–12 weeks	Cochrane review	No information
Wart	Cryotherapy	As effective as salicylic acid which has been shown to be effective	Cochrane review	Burns and nerve damage
Wart	Dinitrochlorobenzene	Significantly better than placebo	Cochrane review	Potentially toxic and hazardous material
Plantar wart	80–90% salicylic acid under an occlusive dressing for one week. Quick and painless	Anecdotal evidence of benefit	Vasarinch P clinical dermatology Butterworths Boston 1982 p 339	None reported
Warts	Intralesional bleomycin	Conflicting evidence on benefit	Cochrane review	Potentially toxic and hazardous material
Warts	Homeopathy	No benefit	2 RCTs Cochrane review	No information
Warts	Surgical removal	No randomised trials	Cochrane review	Risk of scar plus wart
Warts	Levamisole Systemic interferon Hypnotic suggestion	No trials	Cochrane review	No information

NNT = numbers needed to treat; RCT = randomised controlled trial

Members of the Royal New Zealand College of General Practitioners can have access to the full reviews by contacting Cherylyn Pearson at the College in Wellington. For the access codes to the Cochrane library contact cpearson@rnzcgp.org.nz at the College. References are available from B Arroll or the Cochrane Library.